HEALTH INFORMATION TECHNOLOGY BLUE RIBBON TASK FORCE
DRAFT MEETING MINUTES

May 07, 2010
9:00 am

Legislative Building
401 South Carson Street, Room 2134
Carson City, NV 89701-4747

Grant Sawyer State Office Building
555 East Washington Avenue, Room 4412
Las Vegas, NV 89101-1072

TASK FORCE MEMBERS PRESENT:

Carson City:
Peggy Brown
Robert "Rob" Dornberger
Tracey Green, MD
Rick Hsu
Scott Kipper

Las Vegas:
Dr. Raymond Rawson, Chairman
Marc Bennett, Vice Chairman
Bobbette Bond
Chris Bosse
Brian Brannman
Joanne Ruh
Russell Suzuki
Maurizio Trevisan, MD
Glenn Trowbridge

TASK FORCE MEMBERS EXCUSED:

Tom Chase
Charles "Chuck" Duarte
Stephen Loos, MD
Marena Works, RN

Valerie Rosalin, RN
Robert "Bob" Schaich

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) STAFF PRESENT:
Lynn O'Mara, State HIT Coordinator, Director's Office, DHHS
Cynthia Pyzel, Assistant Chief, Bureau of Public Affairs, Office of the Attorney General
Charles Harvey, ARRA Director, Office of Governor
Ernesto "Ernie" Hernandez, IT Manager III, Office of Informatics and Technology, Health Division
Lynne Foster, Division of Health Care Financing and Policy
Joyce Miller, Administrative Assistant, Director's Office, DHHS
Julia Spaulding, Health Program Specialist, Health Division
Mel Rosenberg, Chief of IT, Division of Health Care Financing and Policy
Theresa Presley, IT Professional, Office of Informatics and Technology, Health Division

OTHERS PRESENT:
Alex Tunchek, representing Neena Laxalt
Caroline Ford, Assistant Dean, University Nevada – School of Medicine
Cassie Gentry, College of Southern Nevada
Daphne DeLeon, NSLA/Broadband Task Force
David Brown, Emergency Technology Specialist, AT&T
Deborah Huber, HealthInsight, Las Vegas
Dr. Burlin Ackles, 4SureMD
Dustin Boothe, Senior Disease Investigator, Carson City Health and Human Services
Erin Hager
Hyla Winters, PhD, Associate Vice President for Academic Affairs, College of Southern Nevada
Larry Matheis, Executive Director, Nevada State Medical Association
Michael Pennington, Special Projects Administrator, Community Service Agency & Development Corp.

Patrick Irwin, AT&T
Robert Talley, DDS, Executive Director, Nevada Dental Association
Todd Radtke, Regional Chief Information Officer, Nevada Rural Hospital Partners
Yindra Dixon, College of Southern Nevada

Dr. Raymond Rawson, Chairman, called the meeting to order at 9:00 a.m. He stated that the meeting agenda was posted in accordance with Nevada Open Meeting Law at the Nevada Department of Health and Human Services, the Grant Sawyer State Office Building, the Legislative Building, the Nevada State Library and Archives, and on the Nevada Department of Health and Human Services web site. He also explained that the meeting was being videoconferenced from the Grant Sawyer Building in Las Vegas to the Legislative Building in Carson City, as well as being broadcast live over the Internet.

Dr. Rawson stated that public comment would be taken later during the meeting. He reminded everyone that when speaking to state their name and who they represented, for the record. Also, he commented that as the Chairman, he reserved the right to limit comments to three (3) minutes per person, and would respectfully interrupt if the time was exceeded. He asked that information already presented by someone else not be repeated. In addition, he further explained that our committee follows the Robert's Rule of Order.

Dr. Rawson reminded everyone in Carson City and Las Vegas to please sign the attendance sheet for their location.

Dr. Rawson announced that Governor Gibbons appointed Russell Suzuki to the Task Force. He explained that Mr. Suzuki represents the Nevada Chapter of the Healthcare Information and Management Systems Society. Mr. Suzuki is a small business owner in Las Vegas, has over 10 years of IT experience, and holds a masters degree in computer information systems. In addition, he is a graduate of the United States Air Force Academy and served in the U.S. Air Force as a hospital administrator where he gained expertise in medical records management and medical information systems. During his active duty military career, he was the Clinical Chief Information Officer at the Los Angeles Air Force Base where he led the implementation of the electronics medical records. Mr. Suzuki is also a member of the Southern Nevada Medical Industry Coalition and a Technology Consultant to the Las Vegas Asian Chamber of Commerce.

Dr. Rawson welcomed JoAnne Ruh, appointed to the Task Force in April 2010. In addition, he welcomed Daphne DeLeon, the new Broadband Task Force Chair, who was attending in Carson City.

Dr. Rawson directed Joyce Miller to call the roll.

1. Roll Call and Approval of Meeting Minutes from the April 09, 2010 meeting

Joyce Miller called the roll. She informed the Chairman that Tom Chase was excused and was being represented by Travis Cox, IT Director of the Nevada Health Centers; Chuck Duarte was excused and was being represented by Mel Rosenberg, IT Manager of the Division of Healthcare Financing and Policy; Dr. Stephen Loos was excused, Valerie Rosalin was excused, Robert Schaich was excused and was being represented by Jack Kim, VP of State Government Affairs for the UnitedHealth Group; and Marena Works was excused and was being represented by Dustin Boothe, Senior Disease Investigator for Carson City health and Human Services. Ms. Miller informed Dr. Rawson that a quorum was present.

Dr. Rawson explained that those individuals representing Task Force members had voting rights. He encouraged their participation in the Task Force discussions.

Dr. Rawson asked the Task Force members if there were any additions, corrections or comments to the minutes of the April 09, 2010 meeting. There being none, he asked for a motion to approve the minutes.

MOTION: Glenn Trowbridge moved to approve the minutes from the April 09, 2010 meeting.
SECOND: Marc Bennett
APPROVED: UNANIMOUSLY

2. Announcements
There were none.

3. Approval of Revisions to the HIT Blue Ribbon Task Force Bylaws
Dr. Rawson reminded the members that the need for the proposed revisions were noted during the April meeting. He then asked Ms. O'Mara to explain the changes.

Ms. O'Mara stated that the proposed technical changes were recommended by the Office of the Attorney General. She then referred to Page 1, Section II of the Draft Bylaws. The proposed changes corrected a typographical error and included referencing all relevant Executive Orders pertaining to the Task Force and its Bylaws. The final proposed change was on Page 3, Section IV, Subsection A, specifying a simple majority as constituting a quorum of the Task Force or any of its Subcommittees.
MOTION: Brian Brannman moved to approve the Nevada HITBR Task Force Bylaws with the stated corrections.
SECOND: Glenn Trowbridge
APPROVED: UNANIMOUSLY

4. Informational Item: ARRA HITECH Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) Grant Application for Infrastructure and Interoperability Support for Public Health Laboratories
Dr. Rawson explained that there was a stimulus funding opportunity for state and public health labs. Since the state HIE Cooperative Agreement requires coordination with related HITECH funding opportunities. The State Health Division was planning to submit an application for this supplemental funding, which was expected to enhance public health surveillance through HIT. He introduced Ms. Julie Spaulding to provide an overview of the project.

Ms. Spaulding referenced the "Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) Grant" handout provided to the Task Force. She then explained the intended purpose of the funding opportunity is to enhance and advance infrastructure and interoperability support for public health laboratories to satisfy the stage one Meaningful Use criteria for reporting to public health agencies. The funding would support the ability of state public health laboratories to electronically submit reportable lab results to public health agencies and to hospital laboratories.

Mr. Bennett asked about the competitive scope of the opportunity and if there was funding for all states. Ms. Spaulding responded that there would be 25 awards. Dr. Rawson noted that there was a maximum amount and an average award, and asked Ms. Spaulding what funding level Nevada would be requesting. Ms. Spaulding responded that the Health Division would be requesting the maximum funding award.

5. Staff Reports
Ms. O'Mara referenced the 120-day Calendar (May 4 – August 31, 2010) provided to the Task Force, with key due dates noted. She reported that the Board of Examiners approved the requested contract amendment for the joint HIE-Medicaid environmental scan, which was now in progress, and requested assistance from the Task Force in getting the word out to ensure a representative response rate.

Ms. O'Mara informed the members that the Legislature's Interim Finance Committee had approved spending authority through the end of the current state fiscal year for the HIE Cooperative Agreement. The spending authority request for the upcoming state fiscal year was being submitted for approval during the next committee meeting.

Ms. O'Mara informed the Task Force that the required Preliminary Report was submitted on time to Governor Gibbons on April 30, 2010, and noted that the report was posted on the DHHS HIT Web site, along with the referenced attachments. She also provided a summary regarding the April 26, 2010 National Governor's Association, State Alliance for e-Health regional meeting, which she and Mel Rosenberg attended. ONC and CMS are collaboratively completing an analysis and cross-walk of the new health reform

legislation with the HITECH Act. Ms. O'Mara commented that the State HIT Coordinators have been told that HIT and HIE were expected to play significant roles in health care reform.

Ms. O'Mara noted that she had attended the May 6, 2010 meeting of the Broadband Task Force and provided a requested presentation about the HITECH Act and the HIE Cooperative Agreement. She commented that those Task Force members recognized the need for coordination and collaboration with this Task Force. Ms. O'Mara reported that the statewide Broadband Mapping project was near completion, and that there had been discussion about eventually overlaying those results with the results of the environmental scan.

Ms. O'Mara reported that she would be participating at the HIE Cooperative Agreement Leadership Training and Kick-Off, Summit, which was being held in the Washington, DC area during the week of May 10, 2010, and that all State HIT Coordinators were required to attend. Several Task Force questions regarding some of the Cooperative agreement requirements being addressed by the Task Force Subcommittees, and Ms. O'Mara agreed to do her best to bring back the requested information.

Mr. Rosenberg reported that there were four bidders for the Nevada Medicaid MMIS Takeover RFP, and reminded the Task Force that the procurement included a Medicaid HIE. Dr. Rawson asked several questions regarding the financial aspects of the RFP, which Mr. Rosenberg answered. Mr. Rosenberg went on to explain that if the state chose to expand the planned Medicaid HIE beyond Medicaid patients, a sustainable funding stream would be necessary. He also noted that one of the procurement requirements was for the bidders to provide information documenting how, with additional investment, the proposed Medicaid HIE could become one that met federal requirements if it were to be designated as statewide HIE. Mr. Bennett asked if it was a Federated system that all of the bidders bid on and is it a central data base model of HIE or what was the model that was being used.

Ms. Bond inquired if prescriptions, labs, hospitals and physician offices were included in the bid, if it was comprehensive and what the timeline was. Mr. Rosenberg responded that the two required data sources were the Medicaid MMIS claims data and the hospital discharge data submitted to UNLV's CHIA, Medicaid's contractor. He also commented that the RFP required an interface capability with all of those data sources compliant with federal HIE standards and formats. Mr. Rosenberg commented that the RFP award was expected by the end of June 2010, with the new vendor in production by June 2011.

Ms. Bosse asked if there had been any clinician involvement in the vendor selection process, to ensure that there would be ease of access, information timeliness, and system functionality that clinicians would be able effectively use for enhanced patient care. Mr. Rosenberg explained that the bidders all offer MMIS full services, which include extension to HIE capabilities.

Mr. Bennett asked if physicians would be able to access the data in the MMIS. Mr. Rosenberg replied in the affirmative.

6. Informational Presentations

Dr. Rawson explained that a panel of presenters had been organized to provide information regarding workforce issues related to the adoption of Electronic Medical Records, Meaningful Use and Health Information Exchange. He introduced Ms. Caroline Ford, and requested the she act as the panel moderator.

Ms. Ford first introduced Dr. William Hersh, a nationally recognized expert in this area. A physician and professor, he chairs the Department of Medical Informatics and Clinical Epidemiology at Oregon Health and Science University. Dr. Hersh stated that while he was trained in internal medicine, he longer provides patient care. He explained that Oregon Health and Science University has done much research in this area and has developed several programs around health informatics.

Dr. Hersh presented the information contained in his two-part handout "Meaningful Use of Health Information Technology Requires a Competent Workforce". After citing the overall reasons for increased HIT, he discussed the pending needs for a competent HIT workforce, what was known and unknown about

these needs, how an effective HIT workforce could be built, and the role of the HITECH Act workforce development program.

Dr. Hersh noted that the same barriers to the expansion of HIT exist today that existed six years ago:

- Implementation costs
- Technical challenges
- Lack of systems interoperability
- Privacy and confidentiality issues
- Workforce readiness and training

Dr. Hersh stated that the data indicate that there will be a need for more trained HIT professionals for effective nationwide implementation and utilization of Computerized Physician Order Entry systems, or CPOE, and Clinical Decision Support systems. He noted that about 2 percent of all employees in health care organizations work directly in IT.

Dr. Rawson requested that Dr. Trevisan work with Dr. Hersh regarding an abridged version of Dr. Hersh's presentation for the University Board of Regents, to help them better understand the need for trained HIT professionals.

Dr. Rawson commented that most states do not recognize the economic impact of the health care industry. Dr. Hersh referenced US Bureau of Labor Statistics information in his presentation regarding employment projections for health information management and the growing role of the Chief Medical Information Officer as supporting Dr. Rawson's comment. He also stated that the lack of a Standard Occupational Code (SOC) was an important limitation that needed to be resolved.

Dr. Hersh concluded his presentation noting that Informatics is a maturing discipline and profession, with tremendous growth opportunities. A competent and well-trained workforce is an essential requirement

Mr. Hsu asked Dr. Hersh if there was any interest in coordinating the HIT educational programs presented with MBA programs, where students would have the opportunity to examine the issues from a more comprehensive perspective and develop sustainable business models. Dr. Hersh explained that while nothing formal existed, he agreed with Mr. Hsu that business acumen ought to be part of health informatics. He noted that Duke University has established a center for health informatics which is collaboration with the university's business school.

Mr. Bennett asked about how many hospital employees have been trained in HIT and if there were general IT professionals or other individuals who could be retrained quickly in this field. Dr. Hersh replied that probably less than point one percent of hospital employees had IT training. He noted that the HITECH programs are designed with an emphasis short- term training.

Mr. Bennett inquired that if the workforce issues had been comprehensively examined on a state-by-state basis. Dr. Hersh commented that he was not aware of that being done.

Dr. Trevisan stressed that this type of training ought to be available for both employed and unemployed individuals, either new to IT and already having on-the-job skills and experiences. Dr. Hersh agreed, citing his university's 10 x 10 program. He commented that he expects the need for development of these kinds of programs, with distance learning modalities having the scalability and content necessary to effectively meet training needs.

Ms. Bond cited the difficulty of finding health care professionals willing to bridge the gap between clinical practice and HIT. These individuals would be needed to achieve improved health care quality and population health, in a comprehensive manner. Dr Hersh agreed that these individuals would need to be comfortable working in both worlds, have excellent communication skills, and require their organizations to recognize their value in enhancing health care delivery and outcomes.

Dr. Rawson noted that extensive reports have been done regarding health care manpower needs in the state, and he was not aware that any had ever researched this aspect. He stated that he would share this information with the Regents, as part of the current curriculum review. Dr. Hersh commented on his experience working with the Oregon Healthcare Workforce Institute and what it took for that group to understand similar issues.

Mr. Brannman commented that the state's HIT efforts, including those of this Task Force, were laying the foundation for the subtle changes already occurring in health care. The industry is just now reaching the point where IT applications and clinical processes are converging, and, therefore, we need trained HIT professionals who can assist with gradually ramping up these capabilities, or there is a risk of being overwhelmed by unusable information systems.

Ms. Ford, Assistant Dean, UNR School of Medicine provided information to the Task Force regarding HIT workforce issues in Nevada, via an untitled PowerPoint presentation. She discussed HIT workforce needs and demands, training and certification of professionals, and federal policy and regulations governing HIT, HIE and EHRs. Ms. Ford noted that current employment projection data demonstrate rapid growth and continued acceleration through 2016 for health care practitioners and technicians. She also reported that job projections for medical records and health information technicians increase as investments in health information technology accelerate the growth.

Ms. Ford presented a graph that depicted the actual and projected growth of health-related occupations versus all other occupations, from 2000 to 2016. Growth of health care support occupations was projected at 48%. She noted that compounding the rapid projected job growth for HIT professionals are declining enrollments in computer science and information technology programs and significant labor pool reductions due to baby boomer retirements. Ms. Ford estimated that Nevada's current informatics workforce needs were 5,300 individuals, with the need for 6,400 workers by 2016.

Dr. Rawson asked Ms. Ford if there was an ideal workforce number, and not just a bare minimum estimate. Ms. Ford replied that while the U.S. data was very limited, data collected by Australia, England and Canada, could be used provide a better estimate of workforce needs. She suggested that either a 1:50 or 1:60 ratio would be adequate. Dr. Hersh commented that the number would become higher as HIT moved toward more complex systems.

Ms. Ford shared employment sector information tracked by the Nevada Department of Employment, Training and Rehabilitation. She noted the health care sector data not being collected, which may be inadvertently skewing the results.

Ms Ford cited information from the recent WICHE Report entitled "A Closer Look at Healthcare Workforce Needs in the West - Health Information Technology." She specifically noted that EHRs are expected to reduce the need for medical coders, billers and transcriptionists. Ms. Ford also shared WICHE's recommendations that colleges and universities will have to modify existing degree programs and add new programs to meet the current and future HIT needs of the health care industry.

Ms. Ford noted that beyond getting an actual workforce trained, there was also the issue of attracting and retaining the faculty necessary for developing and implementing the right curriculum.

Ms. Ford stated that Nevada's workforce deficiencies will impact system capabilities to address health IT needs. She reported that Nevada's overall health professions ranking in the U.S. is 45th, with various acute shortages of medical professionals adding to the increased need for HIT professionals. Ms. Ford concluded by making six recommendations to the Task Force:

1) Institute effective intra- and interstate collaboration for health informatics programming;
2) Activate a closer partnership between industry and education to develop a health IT workforce that meets competency requirements;
3) Execute immediate and formal collaboration with Nevada workforce agencies and statewide education programs to address education gaps and resources;
4) Structure incentives to attract new workforce labor, and to train and remain in Nevada;

5) Develop linkages with on-line providers of education to expedite health IT workforce output; and
6) Seek planning and development funding through state/federal resources to develop educational infrastructure.

Dr. Trevisan provided information to the Task Force via a presentation entitled "Health Information Technology: NSHE's Role & the Educational State of the State." He explained that the University intended to take advantage of available ARRA funds for establishing HIT educational programs. Currently, the College of Southern Nevada is participating in the multi-state HITECH grant for the development of one accredited training program for HIT. Led by California, Nevada, Arizona and Hawaii have been awarded $70 million through the Community College Consortia to Education IT Professionals in Health Care to develop HIT certificate programs to support HER adoption. He also explained additional ARRA funding opportunities.

Dr. Trevisan outlined the NSHE efforts to increase HIT educational opportunities, which included the establishment of Task Force, in August 2009, to develop a web-based HIT educational programs that could be used by multiple institutions within the system and across the state. This task force is centered on graduate, undergraduate, certificate and bridge programs for health professional and non-health professional students in the area of health information technologies. Dr. Trevisan noted that the four key challenges are limited faculty expertise, non-recurring program funding, the preference given to existing programs, and high expectations for output. The requirement for the Community College Consortia is to recruit and train 150 students annually, per member community college during the grant period. He stated that in order to achieve success, it was important not to forget that the workforce must be trained through the higher education system.

Dr. Winters presented information contained in the "Health Information Technology Workforce Training" handout. She explained that the College of Southern Nevada, or CSN, is the institution within the Nevada higher education system that has a 10-year old accredited Health Information Technology Program. After introducing two program staff, Dr. Winters reported that this accredited program was the reason CSN was selected to represent Nevada as part of the Los Rios HITECH Consortium, which received the HITECH grant under the ONC Workforce Training program. The program curriculum is being developed by Oregon Health and Science University, and the workforce training must begin by September 30, 2010.

Dr. Winters noted that CSN had a reputation for quickly adapting to student and community needs. CSN's plan to meet the HITECH grant requirements was to offer a Web-based education program that was known to be attractive to their typical student. Dr. Winters commented that the majority of the students currently enrolled in the HIT Program are already employed by hospitals or other healthcare providers. For that reason, the program has been restructured to a weekend environment, minimizing any impact on the students' work schedules.

Dr. Winters stated that over the next two years, CSN expects to receive approximately $ 750,000 for this project. Beyond the two year grant project period, she commented that ongoing sustainability of the program was anticipated based on the success of the incumbent HIT program.

Ms. Bond asked how many students could be trained through the new program. Dr. Winters replied that CSN has committed to train 286 students over the two-year grant period. She said that the college anticipates training approximately 150 students per year, within a six-month block of time, as required by the grant.

Mr. Suzuki asked if CSN was certifying HIT students who completed the program. Dr. Winters explained that students who complete the Associate Degree program are eligible for various HIT certifications, and this new program was not part of the degree program. Mr. Suzuki then asked if there was any overlap between the two programs. Dr. Winters stated that there was no overlap at this time, and there would be in the future.

Mr. Suzuki inquired who may hire these students, once they completed the new program. Dr. Winters replied that it was anticipated the first group of students are going to be incumbent workers staying in their current positions, with their current employers.

Mr. Suzuki asked if the students would be individuals shifting into an EHR role, from their experience as coders, transcriptionists and medical records technicians, or would clinical staff, medical assistants and front desk individuals be more likely to go in that direction. Dr. Winters responded that most current HIT students are medical assistants and front or back office staff. For the new program, the first influx is expected to come from that same group.

Ms. O'Mara commented that the payers had HIT needs that had to be considered. Dr. Hersh offered that while attention to other areas of health care was important, the real focus of HITECH is the clinical arena.

Ms. Bond explained that she represented a coalition that represented both health care payers and purchasers, and offered examples of what the coalition would like to be able to do, once HIE was possible

Dr. Rawson commented that making intelligent use of the data was important to ensure effective patient care. Mr. Brannman agreed and noted that his medical center lacked necessary data. While he has staff ready to analyze data, the medical center currently has limited means to receive what it needs. Mr. Brannman said that he needs competent HIT professionals to help design and implement the HIT systems required to meet HITECH mandates.

Mr. Radtke noted that it was important for hospitals, in particular, to focus on workflows and processes, as they were critical to successful EHR adoption and HIE utilization. It was critical to have trained IT professionals to enable this. He stated that currently our hospitals who have Implemented EHR systems have used nursing staff to work with the IT staff, requiring the addition of temporary nursing staff to ensure safe, quality patient care and adding to the cost of the EHR.

Ms. Ford asked what the impact would have been on the CSN HIT program, if the HITECH grant funding had not been received. Dr. Winters replied that the existing program would have continued, and commented that the new program increases the overall visibility of what HIT training is offered by CSN, and is expected to enrich the CSN's HIT curricula model.

Ms. Ford explained the evaluation framework used by a system of higher education when determining which programs to continue offering. She asked how many HIT graduates CSN would have, if the grant had not been received. Dr. Winters responded that there were 12-15 graduates each year.

Mr. Suzuki noted that in addition to hospitals and physician practices, EHR vendors certified to provide training would also be hiring qualified HIT workers as trainers. He explained that there was an increasing need for this type of HIT professional.

7. HIE Planning Subcommittee Interim Reports

Ms Bond reported that the Subcommittee on HIE Governance and Accountability had held two meetings to date and was focused on researching statewide governance structures that may best enable HIE for health care stakeholders, facilitate meeting Meaningful Use requirements, ensure coordination with Medicaid and public health, support health insurance exchange requirements, protect personal health information, and protect the public interest. At this time, the Subcommittee was recommending a hybrid model as a long-term solution. She also noted that the Subcommittee intended to frame the governance structure around four agreed-upon principles: transparency, accountability, privacy protection and sustainability. Ms. Bond cited two needs: what was being done by the Subcommittee on HIE Technical Infrastructure and determining the various stakeholders.

Ms. Bond cited her concern that the results of the environmental scan would not be available in time for the final report due from her Subcommittee to the full Task Force. Ms. O'Mara suggested that since Subcommittees were all in the same situation, perhaps the Chairman would consider having all the final reports due in time for the July meeting of the Task Force and using the June meeting of the Task Force as a working session, including all Subcommittee members and any subject matter experts. Ms. Bond stated her agreement with that suggestion

Ms. Bond agrees with Ms. O'Mara in putting the report off until they receive the scan and come to that work secession with information regarding how far they have gotten. After discussion by the Task Force, Dr. Rawson agreed with Ms. O'Mara's suggestion, and directed that all final Subcommittee reports would be due July 16, 2010 and a working session of the Task Force and Subcommittees be scheduled during the June 11, 2010 meeting.

Dr. Rawson stated that pursuant the Task Force, he appointed Ms. Ruh as Co-Chair of the Subcommittee on HIE Technical Infrastructure Bylaws of this Task Force and Mr. Suzuki to the Subcommittee on EHR Adoption and Meaningful Use.

Mr. Trowbridge reported that the Subcommittee on HIE Privacy, Security and Patient Consent had held one meeting to date, during which issues regarding the patient consent process, personal health information confidentiality, accessibility and accuracy, and a correction process for personal health information errors. The Subcommittee plans to develop guiding principles, to be used for Bill Draft Requests, along with the results of the legal inventory being done by DHHS.

Ms. O'Mara reported that further privacy guidance for the states was expected from ONC. However, no timeframe has been given as to when that information would be available. She stated that it would be shared with the Task Force and Subcommittees, as soon as it was available.

Mr. Kim suggested that federal laws be reviewed for any potential EHR privacy conflicts, citing drug and alcohol examples. He also suggested that actual written opt-in consent may be required under certain circumstances.

Mr. Bennett reported that the Subcommittee on EHR Adoption and meaningful use had held their first meeting, and reviewed what had been discussed. He noted that the Subcommittee wanted to be certain that there was a sufficient user base of adopted HIT to support successful HIE implementation and utilization.

Ms. Bosse reported that the Subcommittee on HIE Financial Viability and Sustainability had met once and reviewed the HIE grant match requirement, estimated at approximately $800,000. More information was needed about what constituted allowable in kind contributions. The Subcommittee also discussed if the current grant award would be enough to establish a statewide HIE and what might be necessary if more seed funding was needed. The Subcommittee planned to review the HIE budgets from other states regarding sustainability and scalability, as well as sustainability models.

Ms. Ruh reported that the Subcommittee on HIE Technical Infrastructure had met once to date and a draft plan was in process. She stated that this Subcommittee needed to coordinate with the others, and other Task Fore members stated their agreement. Ms. Ruh noted that since she served on two Subcommittees, it would help the coordination between those efforts. She commented that this Subcommittee was focusing on desired functionality and core requirements as a starting point.

Dr. Trevisan recommended that the Subcommittees stressed the necessity of a trained workforce, along with workforce development and educational requirements. Mr. Ruh stated her agreement, commenting that effective workforce training was essential.

Ms. O'Mara reminded the Task Force that the HIE Cooperative Agreement funding cannot be used for workforce training. She commented that the Task Force can make recommendations to Governor Gibbons as regarding what it believes the state requires.

8. Appointments

Dr. Rawson noted that the appointments of Ms. Ruh and Mr. Suzuki had been made earlier during the meeting. There were no further appointments.

9. Public Comment and Discussion

Mr. David Brown, an Emerging Technology Specialist with AT&T, stated that his company is an HIT vendor. AT&T provides related telecommunication services and is also an applications service provider for HIE environment. He requested the opportunity to discuss the topic with the Task Force.

Ms. O'Mara asked if AT&T had submitted a related ARRA Broadband grant application. Mr. Brown replied in the negative. He stated that AT&T's HIE application supported a federated environment for complete HIE of data between various applications and environments. Ms. O'Mara asked Mr. Brown to please provide Ms. Miller with his contact information, so that she could schedule a meeting.

Ms. O'Mara informed the Task Force that the next meeting is scheduled for Friday, June 11, 2010 at 9:00 am. She requested that agenda items be submitted to her by June 1, 2010.

10. Adjournment

Dr. Rawson adjourned the meeting at 12:24 p.m.

Health Information Technology Blue Ribbon Task Force

June 11, 2010

Agenda Item #3 – Informational Item: Senate Bill 319
Unique Patient Identification Mechanism and HIE Requirements

Overview of SB 319, Section 22:

> 1. The Health Division of the Department of Health and Human Services shall, in cooperation with medical facilities, providers of health care and any agency of the Federal Government, investigate options for creating a unique patient identification mechanism to allow a patient to be identified from one facility or provider to another without requiring the disclosure of a social security number.
>
> 2. The Health Division shall, on or before July 1, 2010, report the results of its investigation to the Legislative Committee on Health Care (LCHC).

Stakeholder Meeting - Wednesday, May 12, 2010:

- Originally proposed to address health care quality
  - Tracking readmission rates for hospitals
- Challenges with creating a Federally assigned unique ID
- Now critical to HIT and HIE

Possible Solutions:

- Algorithm using identifiers to uniquely identify individuals
- Other Issued Number
  - e.g. State of Issuance and Birth Certificate Number

Next Steps:

- Report to LCHC
- Research into what other states are doing
- Define possible algorithm
- Seek further feedback from stakeholders
- Partnership with HIT Task Force and Subcommittees

Questions?

Alicia Chancellor Hansen, MS Chief Biostatistician

Nevada State Health Division

Tom Deas, MD

Executive Board, North Texas Specialty Physicians
Chief Medical Officer, Sandlot, LLC

Nevada Office of Health Information Technology
Blue Ribbon Task Force
Friday June 11, 2010

North Texas Specialty Physicians (NTSP)

- Physician governed IPA in Fort Worth, TX (Tarrant County)
- 600 specialty and primary care physicians delivering care to 15,000 residents per day of Tarrant, Johnson, and Parker Counties
- Accepts risk for over 25,000 Medicare lives
- Belief: patient records should be real-time and available to all treating providers
- A physician-led organization focused on innovation and technology created Sandlot, LLC, a regional Health Information Exchange (HIE) in 2006

Case Scenario

A patient faints after arriving in my waiting room

Action: Our HIE revealed that the patient was diabetic with recurrent nausea and vomiting with a recent hospital admission.

Results: The patient was treated in the office and allowed to return home

Budget impact: An ambulance trip to an emergency room and possible hospital admission were avoided

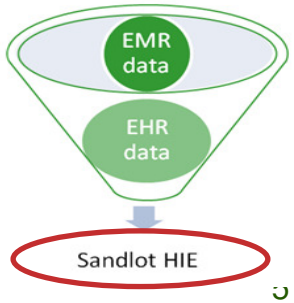
Patient impact: Patient received timely intervention and appropriate care at the initial point of care.

Keys to HIE Success

- Eliminate “silos” with true interoperability
- Assure ease of adoption with efficient clinical workflow
- Incentivize early adoption to achieve critical mass
- Patient (population) confidence
- Sustainable financial model

A truly interoperable HIE eliminates information silos

- Takes an Electronic Medical Record (EMR), which is a document electronically created during a patient visit
- Incorporates that new EMR into the patient's Electronic Health Record (EHR), which is the patient's medical history
- Parses information securely in real time and across disparate interoperable systems, EMRs and data sources
- Ensures the EMR and EHR can be displayed for providers throughout the community at the point of care



Questions to ask when searching for an HIE partner

- How specifically will the HIE improve decision-making, diagnosis and treatment for the patient?
- How will the HIE improve monitoring and management of chronic, complex medical conditions?
- How will the HIE inspire patient confidence in the care they receive?
- How specifically does the HIE control redundancy and reduce medical cost?

How will health care delivery in Nevada benefit from an HIE?

- Shared patient information achieves cost savings
- Care is delivered more efficiently with less duplication of resources
- Fewer medical mistakes means better care at lower cost
- Safety and security of clinical information increases patient confidence
- Medicaid fraud detection yields cost savings

How will care delivery in Nevada benefit from an HIE?

- Community health assessments provide better care management and a healthier community
- Outbreaks and epidemics can be closely monitored across the community to provide timely assessments
- Provides access to federal funding
- Facilitates Accountable Care Organizations (ACOs) and care management

What HIE benefits will your doctors and healthcare providers desire?

- Physician driven technology is more easily integrated into the practice increasing adoption rates
- More efficient workflows
- Best of breed technology integration
- Emphasis on low tech services for adoption, training, and utilization
- Interoperable systems that communicate and share clinical data at the point of care (eliminates information silos)
- Economic sustainability

Quality Care Management

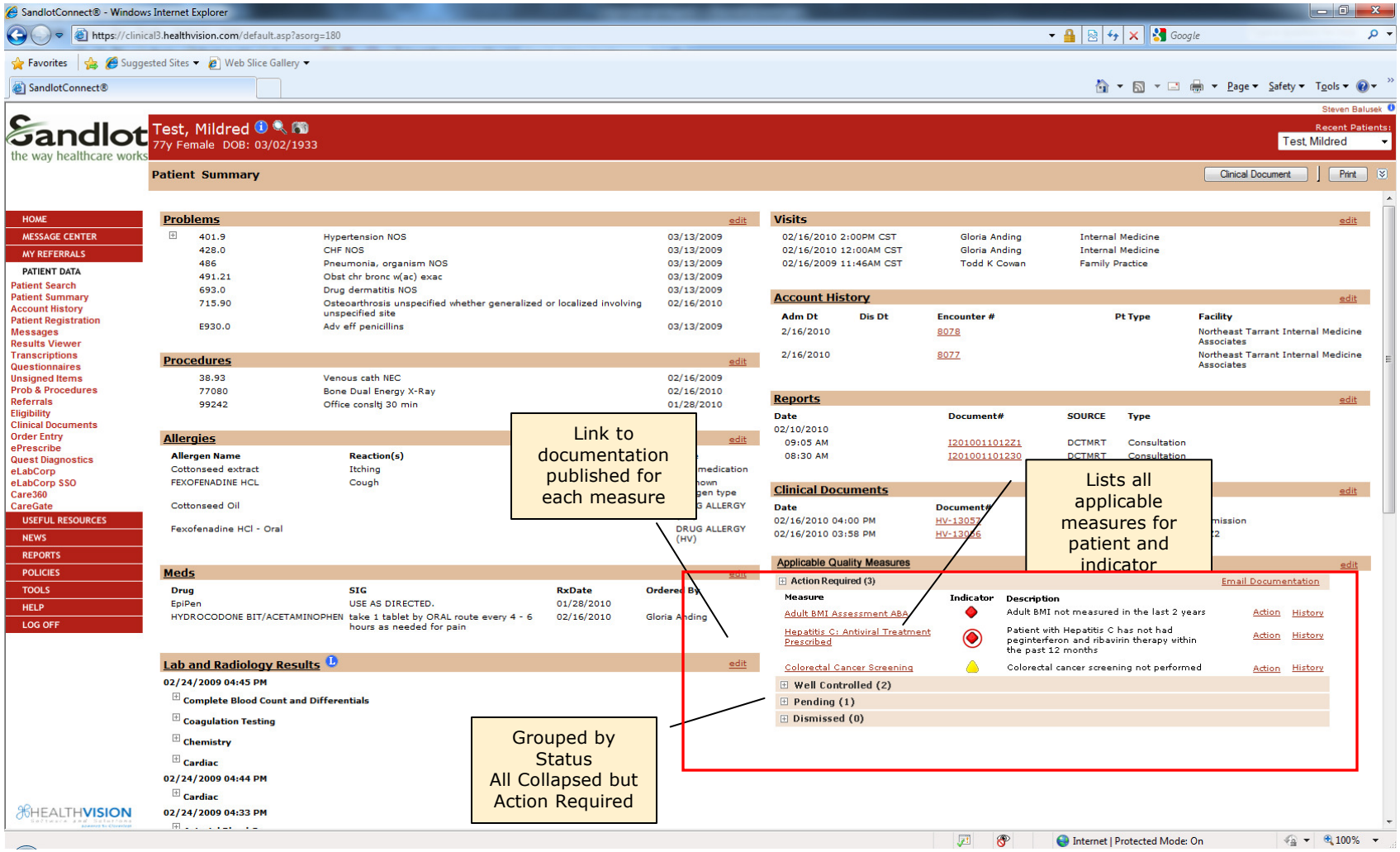
Taking clinical information to a higher level of care

- clinical decision support
- customizable reporting
- triggered alerting & reminder systems

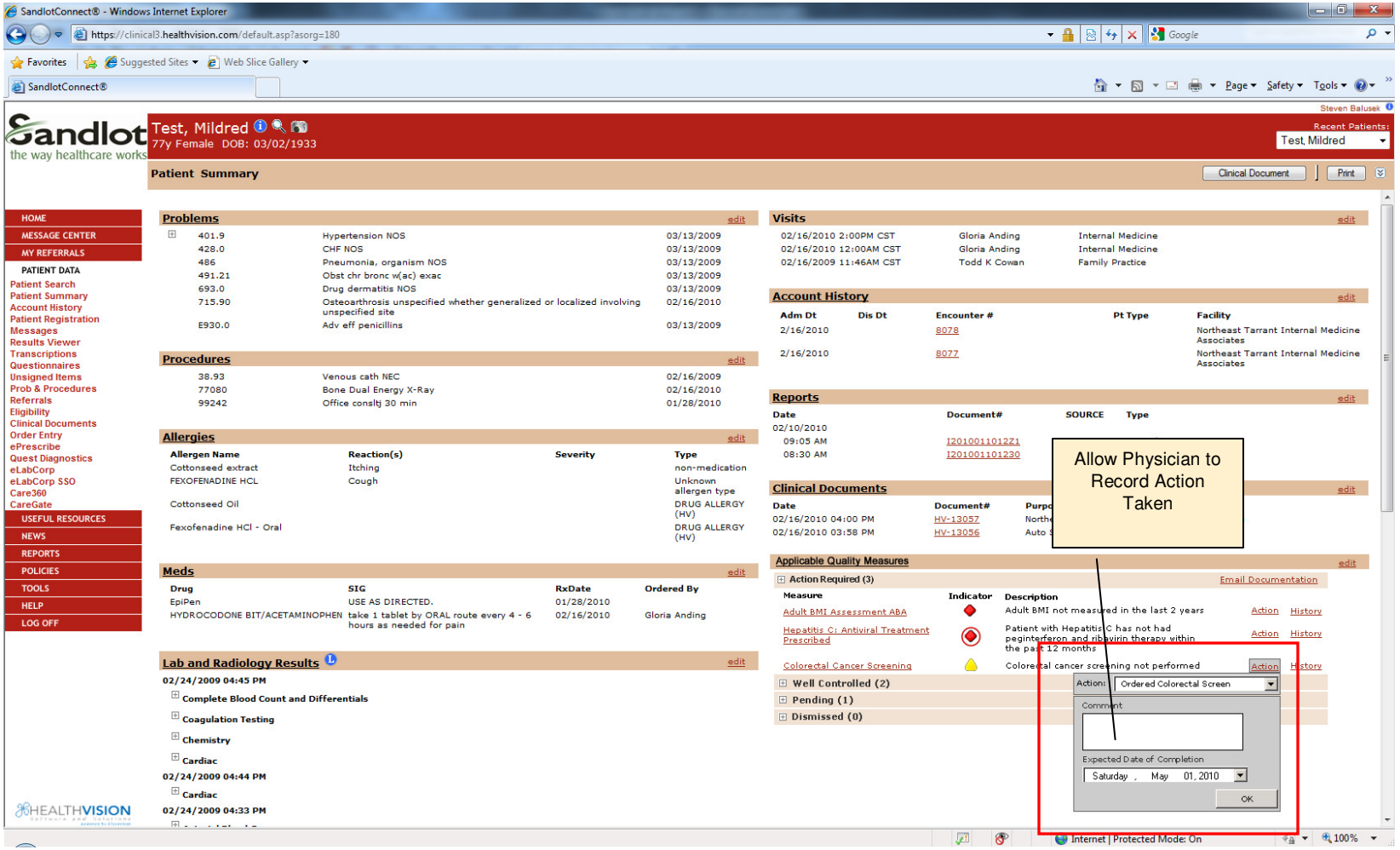
Quality measures:

- HEDIS
- PQRI
- Ad hoc quality measures

Point of Care Decision Support Module
Patient Summary



Point of Care Decision Support Module
View Patient Summary (Take Action)

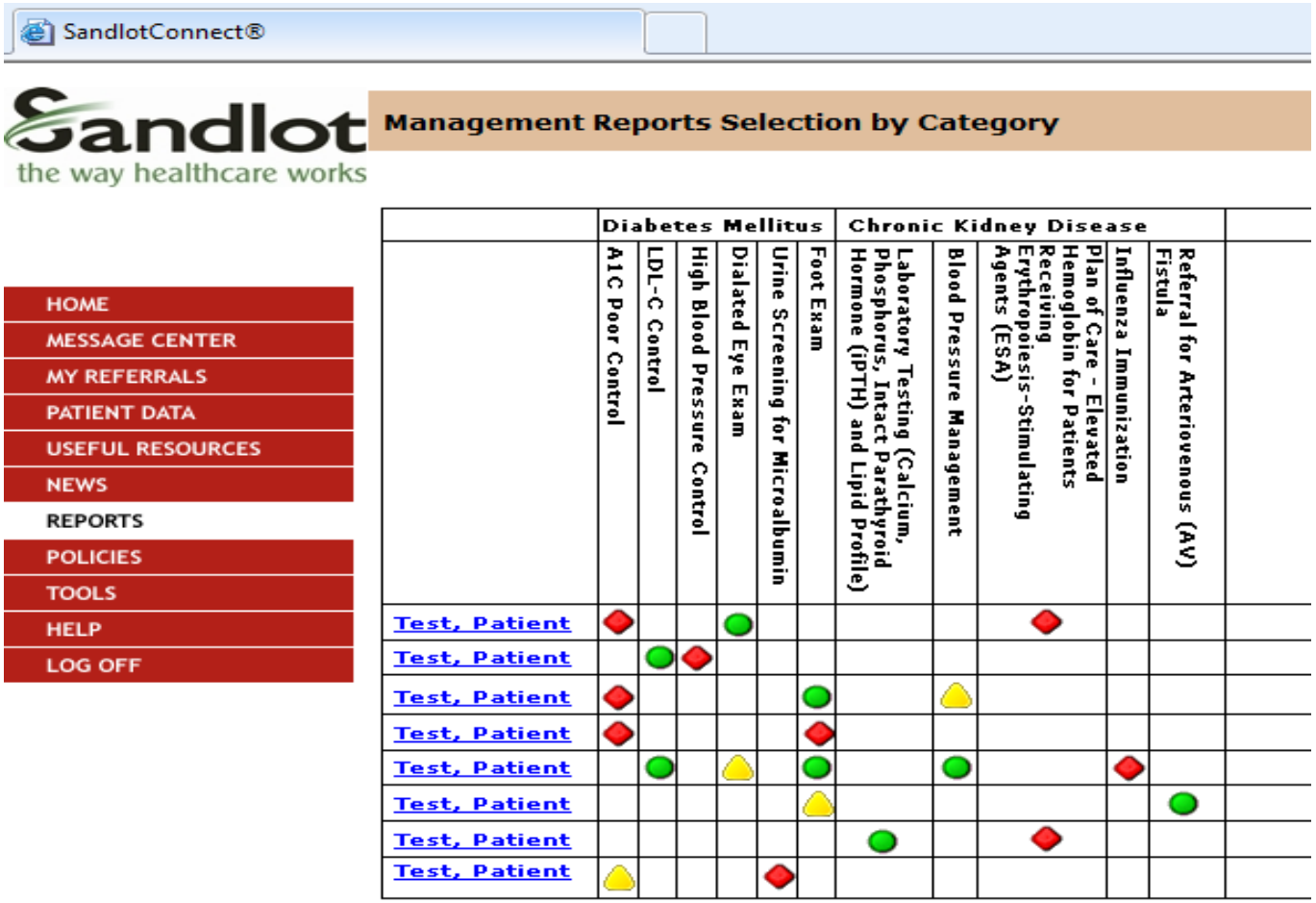


Quality Scorecard

Patient Population Quality Measures edit

Select Context: My Patients			Comparison Population: My Practice	
Measure	**Action Required**	**Ratio**	**% Diff vs Comparison**	**Ratio**
Group: Diabetes Mellitus				
A1C Poor Control	5	10/15 (66%)	↑ +16%	50%
Low Density Lipoprotein (LDL-C) Control	4	2/6 (33%)	↓ -7%	40%
High Blood Pressure Control	1	3/4 (75%)	↑ +25%	50%
Dilated Eye Exam	3	6/9 (66%)	↑ +33%	33%
Urine Screening for Microalbumin	8	12/20 (60%)	↑ +40%	20%
Foot Exam	5	5/10 (50%)	↑ +10%	40%
Group: Gastroenterology				
Prventative Care andScreening: Colorectal Cancer Screening	4	15/19(79%)	↓ -20%	59%
Hepatitis C: Antiviral Treatment Prescribed	1	1/2 (50%)	↑ +11%	39%
Hepatitis C: Hepatitis A Vacination in patients with HCV	1	3/4 (75%)	↑ +15%	60%
Hepatitis C: Hepatitis B Vacination in patients with HCV	8	12/20 (60%)	↑ +5%	55%
Endoscopy & Polyp Surveillance: Colonoscopy Interval for patients with a History of Adenomatous Polyps - Avoidance of Inappropriate Use	3	6/9 (66%)	↓ -4%	70%

Measure Reporting



Quality Module Physician Functions

Physician/Designee

View Quality Scorecard

Quality Scorecard

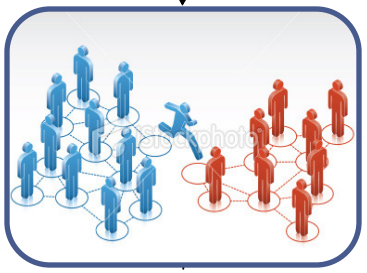
Drill to Population Reporting

Population Reporting

Drill To Patient Registry By Measure

View Measure Report(s)

Measure Reporting



Patient Registry

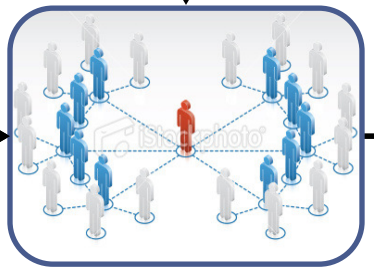
Drill To Patient Summary

SSO Via EMR

Configure Measures

Measure Configuration

View Patient Summary



Patient Summary

Take Action

Dismiss

Take Home Lessons

- Pick a partner that has already invented a wheel that works
- Assure ease of adoption of technology
- Eliminate information silos
- Maximize security and audit capability
- Pursue a critical mass of physician and community adoption
- Convince patients (population) of the opt-in value
- Anticipate training and education for the new job opportunities
- Create financially sustainable model
- Focus on quality improvement

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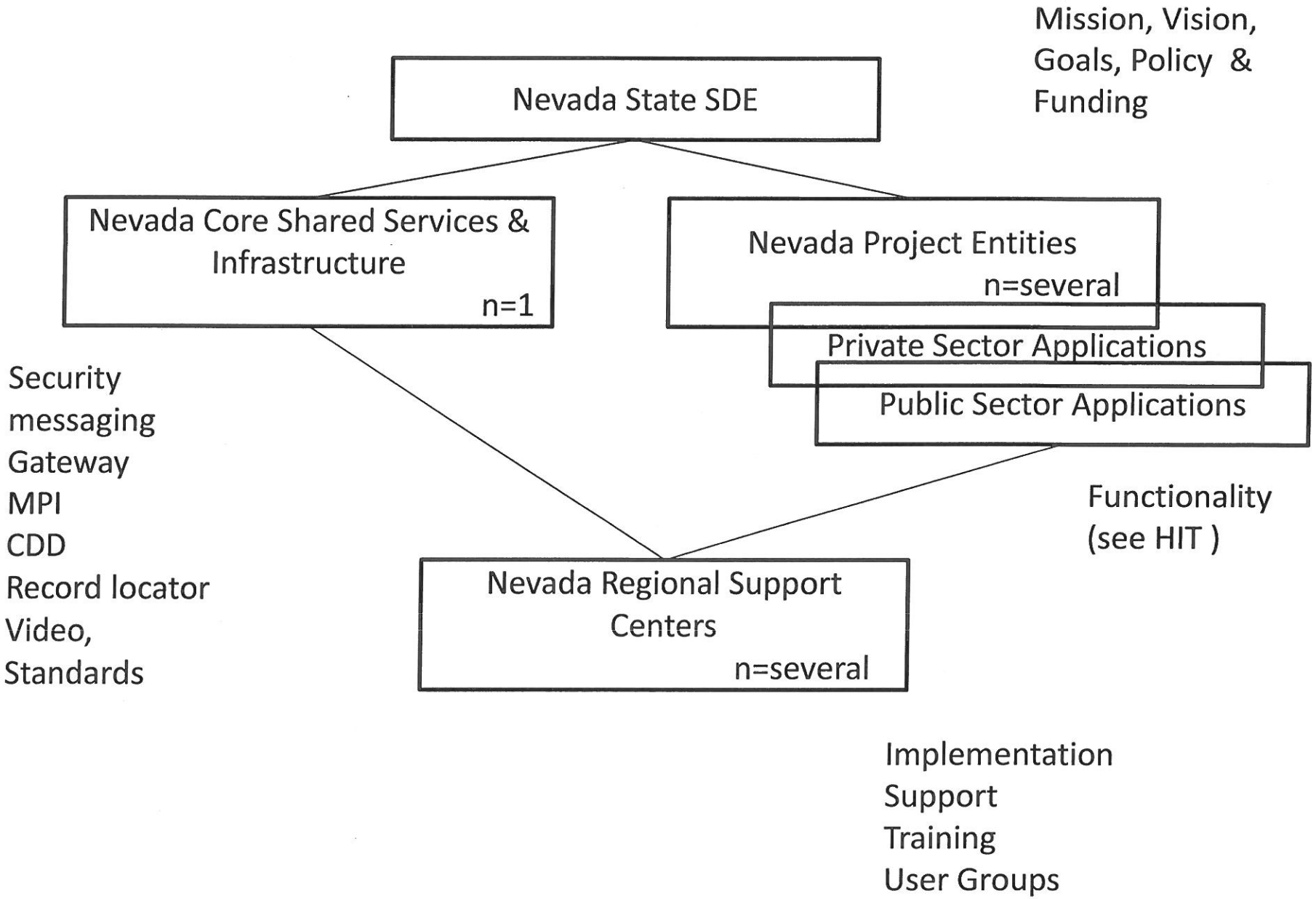
Mission, Vision, Goals, Policy & Funding
Nevada State SDE
Nevada Core Shared Services & Infrastructure
n=1
Nevada Project Entities
n=several
Private Sector Applications
Public Sector Applications
Security
messaging
Gateway
MPI
CDD
Record locator
Video,
Standards
Functionality
(see HIT)
Nevada Regional Support Centers
n=several
Implementation
Support
Training
User Groups

Health Information Technology Blue Ribbon Task Force
Subcommittee on Financial Viability and Sustainability
June 11, 2010

HIE Cooperative Agreement Funding Match Requirements

Grant Year	Estimated Match
Year 1	$ 63,035
Year 2	$280,758
Year 3	$202,688
Year 4	$250,787
TOTAL	**$797,268***

***** if state Contingency Fund balance is allowed to be carried forward, the total match requirement would be reduced to $632, 268

Match requirements are documented in the Nevada HIE Cooperative Agreement Notice of Funding Award Terms and Conditions, in 45 CFR Part 92, and in OMB Circular A-87:

Non-federal Cash Match

- Approx. $165,000 from Contingency Fund
- Qualifying Revenues from the HIE entity/organization, if funded by HIE grant
- Gifts, donations, bequests, and non-federal grants

In Kind Match

- UNR Students time
- Some Task Force and Subcommittee members time
- Donated office equipment and/or contract time
- Donated office/meeting space
- Donated telecom/web services
- Donated professional services (accounting, lawyers, consultants, etc.)
- Donated refreshments
- Donated volunteer time

Notes

- The total amount of the match is based on projected spending levels during each year of the grant period of performance. Failure to spend the projected amount in one grant year would result in an increased match requirement the following year, at the higher match rate.
- During a grant year, if the projected grant funds are spent, and the match is not met, the difference can be made up in a subsequent year, without a multiplier kicking in, as long as the total match is met by the end of the grant period of performance.
- There is no limit on how much of the match can come from In Kind sources.
- In Kind match can begin from February 8, 2010.

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LAS VEGAS, NV 89101
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WWW.ACLUNV.ORG

To: Glenn Trowbridge, Subcommittee Chair
Date: April 20, 2010
Re: HIT Privacy Subcommittee

Thank you for your request for feedback from the ACLU regarding our privacy priorities related to the Health Information Technology Blue Ribbon Task Force. Included in this memo is your list, with one minor recommended change, and additional recommendations for the subcommittee to consider.

In general, the ACLU urges the subcommittee to prioritize the flow of health information by recommending that information be controlled by patients, that information is compartmentalized or segmented to keep private the most sensitive data, and that the sale of any health data is absolutely prohibited without fully informed consent. We also believe that health information should never be disclosed without either the patient's consent or a court order.

Please let me know if you have any questions.

Rebecca Gasca

Here is the list you provided with possible recommendation the subcommittee on HIE Privacy, Security and Patient Consent should offer. The ACLU of Nevada's recommended change is written in red:

- Recognize that individuals own their health data
- Give individuals control over who can access their electronic health records
- Give individuals the right to opt-in or opt-out off electronic health systems
- Give individuals the right to segment sensitive information
- Require audit trails of every disclosure of an individual's health information
- Require that individuals be notified when their health information is accessed and by whom
- Require that individuals be notified of suspected or actual privacy breaches within a reasonable length of time
- Provide meaningful penalties and enforcement for privacy violations
- Require that health information disclosed for one purpose many not be used for another purpose without informed consent
- Ensure that individuals cannot be compelled to share electronic health records for any reason, including but not limited to obtaining employment, insurance, credit, or admission to schools
- Deny employers access to employees' medical records
- Preserve and permit stronger protections in the NRS

These are additional issues that the ACLU would also suggest the subcommittee consider recommending:

- Enable individuals to easily obtain free, encrypted electronic copies of their records and correct or amend their personal health information
- Provide incentives for user interfaces to be accessible for patients with disabilities
- Prohibit entities from obtaining contractual rights to own or control personal health information
- Personal health information obtained for one purpose must not be used for other purposes. Require periodic audits of contracts with covered entities and business associates
- Prohibit any direct or indirect remuneration for the sharing, disclosure or use of personal health information without explicit consent and a meaningful explanation of what said action would entail
- Give patients access not only to their records, but also to the associated audit trails
- Require all entities that create, maintain, use, or disseminate personal health information to publish a privacy policy written at an 8th grade reading level.
- Require every entity with access to personal health information to ensure the accuracy and reliability of the data for their intended use and take all precautions to prevent misuses of the data
- Require random audits by the Department of Health and Human Services (DHHS) with enforceable penalties. Prohibit entities from obtaining contractual rights to own or control personal health information.
- Require the HIT systems to be able to segment sensitive information.
- Prohibit the inter-governmental sharing of personal health data